Critical Incident Reporting Trend Analysis: 2013

2013 Critical Incident Reporting: Trend Analysis

OVERVIEW

The Division of Developmental Disabilities (DDD) created an online reporting system for Critical Incident Reports (CIR) that was implemented on January 1, 2005. The system allows Community Support Providers (CSPs) to submit required reports electronically and allows the DDD to analyze data. The purpose of developing an online reporting system was to streamline the reporting process for CSPs. Implementation of this system coincides with the first day of the calendar year; therefore, CIR Annual Reports are issued according to the calendar year rather than the fiscal year.

The population covered by the CIR system includes all people receiving services funded through the DDD's CHOICES Waiver[1], Community Training Services (CTS) and private ICF/IID (LifeScape). Policy Memorandum 11-02 stated that although the DDD does not have authority to require providers to report allegations of abuse, neglect, exploitation of non-division funded persons, it is good due diligence to report these allegations. Providers have obtained releases of information from these participants and/or their guardians who do not receive Home and Community Based Services (HCBS) or CTS. Providers began submitting these incidents in September 2010.

The ninth annual CIR report that provides a summary review of the data submitted by the nineteen CSPs and one private ICF/IID, aggregated for calendar year 2013. The DDD's intent is to issue a comprehensive trend analysis on an annual basis while providing specific reports to each CSP on a quarterly basis. The purpose of the report is to communicate information about trends, remain vigilant for emerging issues, and use data to plan, prioritize and implement preventative and proactive initiatives. The DDD hopes that these reports will be helpful to administrators in support of their organization's continuous quality assurance and improvement systems, including managing their internal incident reporting system and comparing their data with statewide aggregate information.

Included in this document is a data analysis of all CIRs for all providers for 2013 including:

- Total number of persons supported by CHOICES waiver, CTS funding, and private ICF/IID funding;
- Total number of incident reports submitted;
- A breakdown of reports by category; and
- Information regarding the total statewide number of incidents by category.

[1] CHOICES is the name of the Division of Developmental Disabilities' Home and Community Based Services Comprehensive Waiver. It is an acronym for Community, Hope, Opportunity, Independence, Careers, Empowerment, Success. In this report, the term HCBS will be used to reference the CHOICES waiver program.

The process for managing the CIR system is a joint collaboration between the DDD and each of South Dakota's CSPs. Each CSP is commended for fulfilling the responsibilities related to CIR notification to the DDD, submission of CIRs, and responsiveness to the DDD's requests for follow-up.

Each CSP is each assigned a Program Specialist who is responsible for reviewing all CIRs submitted by that CSP. DDD nurses review all CIRs that involve health, medication, injury, unplanned hospitalizations or medication issues. The DDD also has a CIR/QA team that coordinates a peer review process for all CIRs. The peer review process is designed as a quality assurance mechanism to ensure that all necessary follow-up is completed, timelines are met, and that any additional third party reporting (e.g., to the Attorney General's Medicaid Fraud Control Unit, law enforcement, Department of Social Services) has occurred. The peer review process has increased the DDD's ability to address CIR inconsistencies both internally and systemically.

The CIR/QA team also collects quarterly data and reviews trends by provider and CIR category. A root cause analysis process is used to determine areas of concern that might benefit from changes in policy and practice. A root cause analysis is a process for identifying the basic or causal factor(s) that underlies variation in performance, including the occurrence of a sentinel event. As trends are identified, DDD Program Specialists are responsible for addressing issues with their assigned provider.

SYSTEMS IMPROVEMENTS IN 2013

1. CIR/QA team implemented the practice of reviewing all mortality reports on a monthly and quarterly basis to ensure accuracy in reporting as well as appropriate action taken to identify trends per provider and system-wide. If warranted, incident information will be forwarded to a South Dakota Developmental Center Physician's Assistant for review;
2. DDD Program Specialists training includes an initial orientation, with updates and issues addressed during regularly scheduled staff meetings to ensure consistency in the review of CIRs;
3. The CIR/QA team continually analyzes processes within DDD in order to ensure that data collection is efficient and consistent on a monthly, quarterly, and annual basis;
4. The CIR/QA team continues to evaluate the current process for assigning peer reviews and quarterly reviews. This process ensures that reviews occur in a timely fashion, consistently, and that follow-up occurs by the Program Specialist as well as the CSP;
5. CIR/QA team monthly meetings include opportunity for DDD Program Specialists to inquire about a particular incident or trend in incidents, clarification of expectations, etc.;
6. CIR/QA team re-assessed the determination of sample size for internal quarterly incident review to better reflect trends based on CSP population;
7. CIR/QA team identified the need to include and add "Hospital" into the dropdown options under Place of Death within Mortality Reporting;

8. Administrative Rules of South Dakota (ARSD) was promulgated December 3, 2013, with changes to better reflect the current reporting system and mandatory reporting laws;
9. DDD Program Specialists provided eight CIR trainings to individual providers during 2013;
10. Through quarterly analysis of incident reporting, the CIR/QA team was able to identify reporting trends by provider and communicate recommendations to address issues through the assigned Program Specialists; and
11. The Office of Community Living will be using CIR data to identify opportunities to develop community capacity and improve transitions to community based settings.

REGULATORY AUTHORITY

The authority behind the submission of incident reports is as follows:

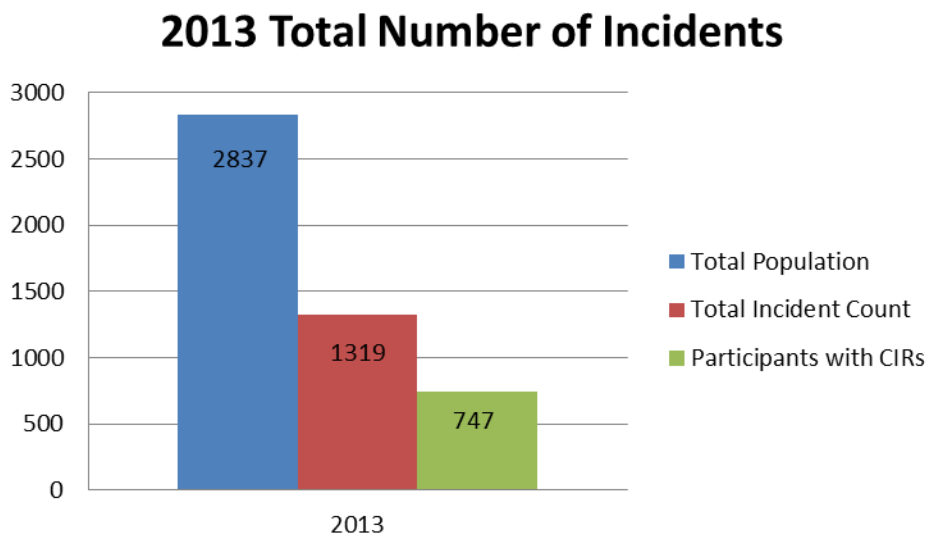
Administrative Rule of South Dakota 46:11:03:02. Critical incident reports – Submission to division. The CSP shall give verbal notice of any critical incident involving a participant to the division no later than the end of the division's next business day or the CSP's administrative business day whichever occurs first from the time the CSP becomes aware of the incident. The CSP shall submit a written critical incident report utilizing the division's on-line reporting system within seven calendar days after the initial notice is made. A report must be submitted for the following:

(1) Deaths;
(2) Life-threatening illnesses or injuries;
(3) Alleged instances of abuse, neglect, or exploitation against or by any participant;
(4) Changes in health or behavior that may jeopardize continued services;
(5) Serious medication errors;
(6) Illnesses or injuries that resulted from unsafe or unsanitary conditions;
(7) Any illegal activity involving a participant;
(8) Any use of physical, mechanical, or chemical intervention, not part of an approved plan;
(9) Any bruise or injury resulting from the use of a physical, mechanical, or chemical intervention;
(10) Any diagnosed case of a reportable communicable disease involving a participant; or
(11) Any other critical incident as required by the division.

The report must contain a description of the incident, specifying what happened, when it happened, and where it happened. The report shall also include any action taken by the CSP necessary to ensure the participant's safety and the safety of others and any preventative measures taken by the CSP to reduce the likelihood of similar incidents occurring in the future. The division may request further information or follow-up related to the critical incident.

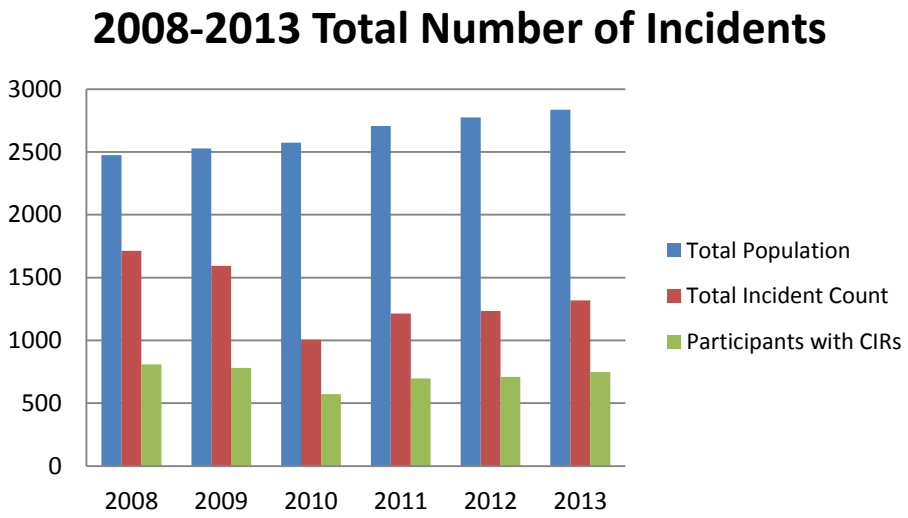
The CSP shall notify the participant's parent if the participant is under 18 years of age, or the participant's guardian, if any, that a critical incident report has been submitted and the reason why unless the parent or guardian is accused of the incident.

2013 ANNUAL DATA:



In 2013, the number of persons supported through HCBS, CTS and Private ICF/IDD funding increased by 61, and the number of participants for whom critical incidents were reported also increased by 36 participants from 2012.

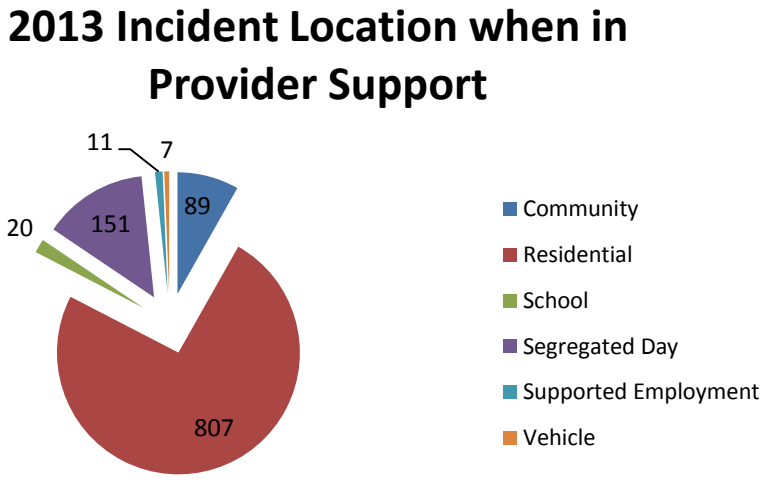
The total incident count for 2013 was 1,319, an increase of 85 incidents from the previous year. These incidents were submitted for 747 participants, or 26.3% of all participants in South Dakota receiving supports and services through CHOICES, CTS or Private ICF/IID.



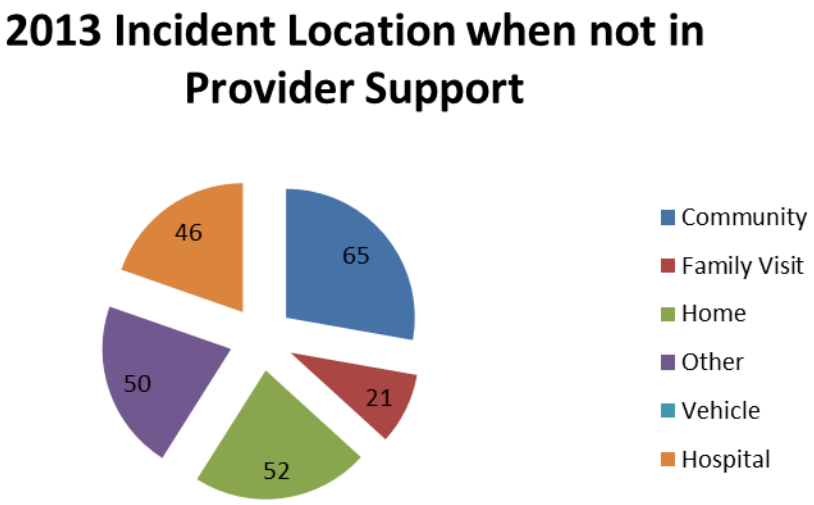
	Total Population	Total Incident Count	Participants with CIRs	% of Participants with CIRs
2008	2475	1714	809	32.69%
2009	2528	1594	782	30.93%
2010	2575	1004	572	22.21%
2011	2707	1213	698	25.79%
2012	2776	1234	711	25.61%
2013	2837	1319	747	26.33%

The total population of participants supported in South Dakota has grown on average per year by 72 participants since 2008. The total population has increased overall in the past six years. Although there was an increase in incidents in 2013, this may be attributed to the fact that the number of participants has increased; as well as supporting people with more challenging needs, therefore multiple CIRs are reported for those people.

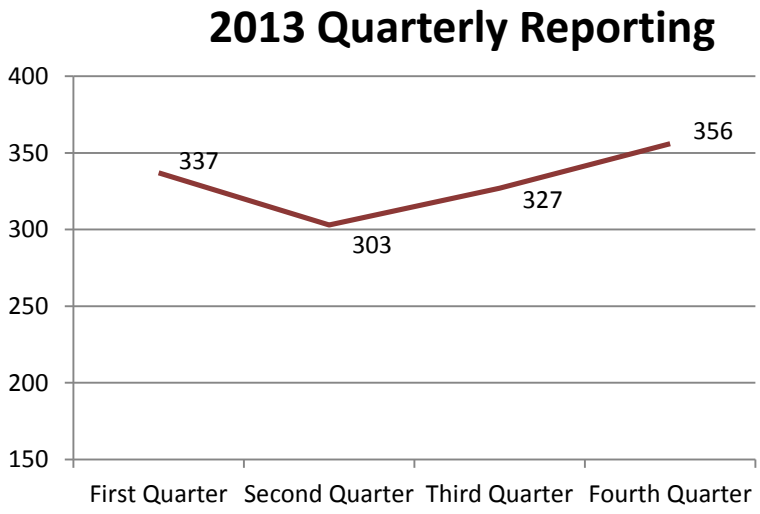
The table above reflects the fluctuation in population, incident count, and number of participants for whom CIRs were reported. The difference in the number of total incidents versus the number of participants is due to the fact that several CIRs may be submitted for the same participant throughout the year. The column "% of Participants with CIRs" is calculated by dividing the number of participants with CIRs by the total number of participants.



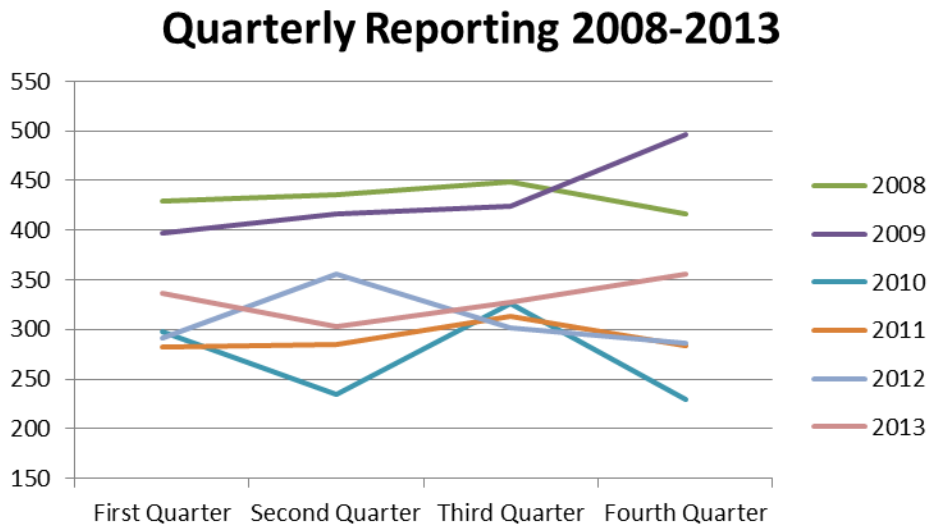
While receiving provider support, incidents primarily occur at residential settings and segregated day settings. Participants are likely spending most of their time in these environments, as 807 incidents occurred in residential settings and 151 incidents occurred in segregated day settings. Significantly less incidents occur while participants are at other locations in the community, supported employment, school, and in vehicles. The data may also indicate that incidents are less likely to occur when participants are partaking in activities outside the home and segregated work settings.



Incidents that occur while people are outside of provider support happen most frequently in the "community" with 65 reports. This data reflects that participants are accessing the community by themselves or with natural support networks and includes a variety of locations. Fifty-two incidents occurred while people were at Home, which encompasses participants who reside in a supported living environment and receive minimal residential supports as well as participants who live in a home with family members. Fifty incidents occurred at "other" locations, which include, but are not limited to, clinics, hospitals, and local events/businesses. In 2013, the option of Hospital as a location for incidents to occur was added, as many CIRs were identified as to have been occurring in that location. All areas of this above graph decreased with the exception of Family Visit, which increased by four.



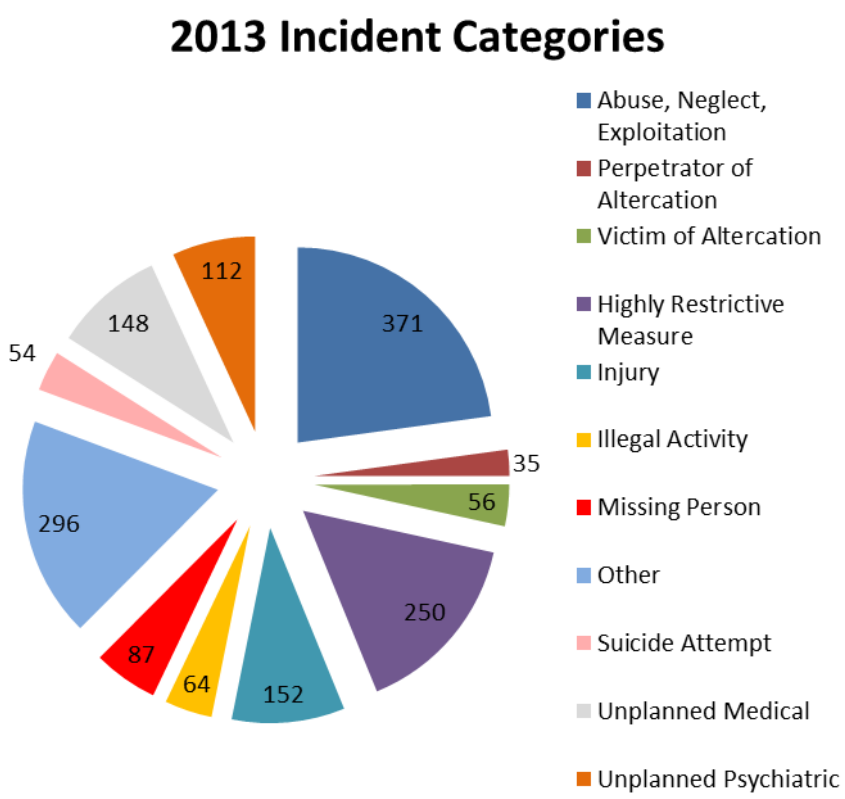
In 2013, quarterly reporting decreased during the second quarter, (April 1 through June 30) which is not consistent with previous years' data. Increases typically occurred in the second and third quarters in previous years.



	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
2008	429	436	448	416
2009	397	416	424	496
2010	298	234	326	229
2011	282	285	313	284
2012	291	356	301	286
2013	337	303	327	356

Since 2008, quarterly incident trends have remained fairly constant, with incident numbers increasing in the second and third quarters. An exception occurred in 2009 and 2013 when incidents numbers increased in the fourth quarter.

Between the years 2009 and 2010, the incidents reported nearly decreased by half each quarter. Further analysis revealed that there were many system improvements relating to CIRs including updated CIR guidelines, CIR/QA team began evaluating the process for which peer reviews, quality assurance and quarterly incident reviews are completed, CHOICES waiver manager joined the CIR/QA team and formal training for new and existing DDD staff was developed and implemented.

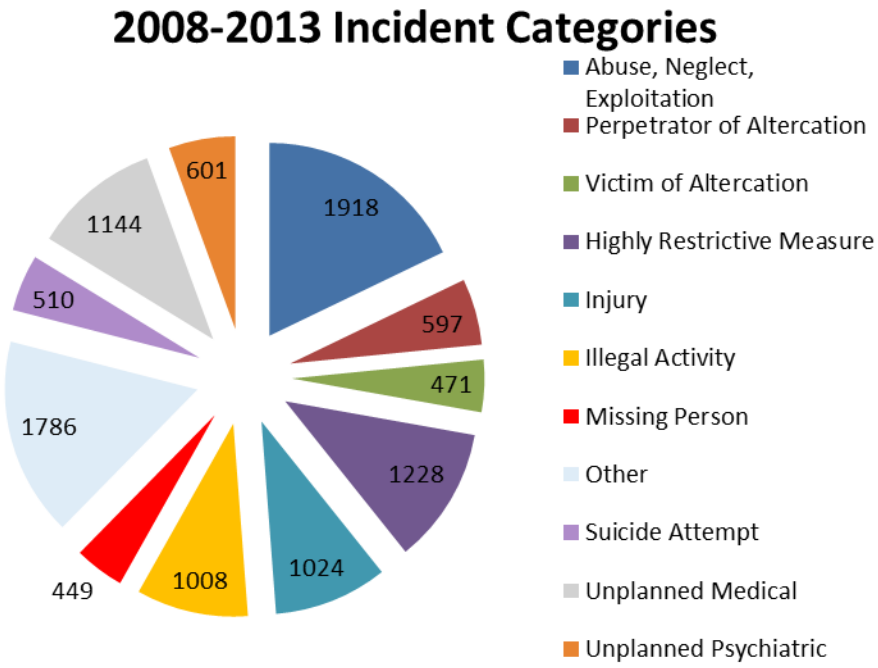


In 2013, the Critical Incident Reporting category most frequently reported to DDD was Abuse, Neglect and Exploitation (ANE) with 371 incidents. This is an increase of 28 reports from the previous year's data. The second highest category reported was the Other category, with 296 incidents. The Other incident category includes:

- Community Complaint;
- Increase in Behavioral Issues;
- Jeopardizing Personal Safety;
- Jeopardizing Services;
- Medical Diagnosis;
- Medication Error;
- Use of Illegal Substances;
- Vehicle Accident;
- Victim of Fire;
- Victim of Theft; and
- Communicable Disease.

Highly Restrictive Measures was the third most frequently reported with 250 incidents, followed by Injury (152). The category with the lowest number of incidents reported to the DDD was Perpetrator of Altercation with 35 reports. The number of incidents in the

following categories reflects a decrease from previous years' data: Perpetrator of Altercation, Illegal Activity, Other and Unplanned Psychiatric categories.



Incident reporting trends for 2008 through 2013 are consistent with 2013 reporting with ANE and Other being the most frequently reported incidents over the past six years. ANE reporting has ranged from 217 reports in 2010 to 371 reports in 2013, with an average of 320 incidents between 2008-2013.

Incidents in the Other category total 1,786 from 2008 through 2013. Reporting in this category has generally decreased since 2008. In 2013, this category indicated a decrease. This is attributed to both the providers and program specialist being able to better identify correct categories rather than selecting 'Other'.

Incident reporting in the remaining categories is as follows:

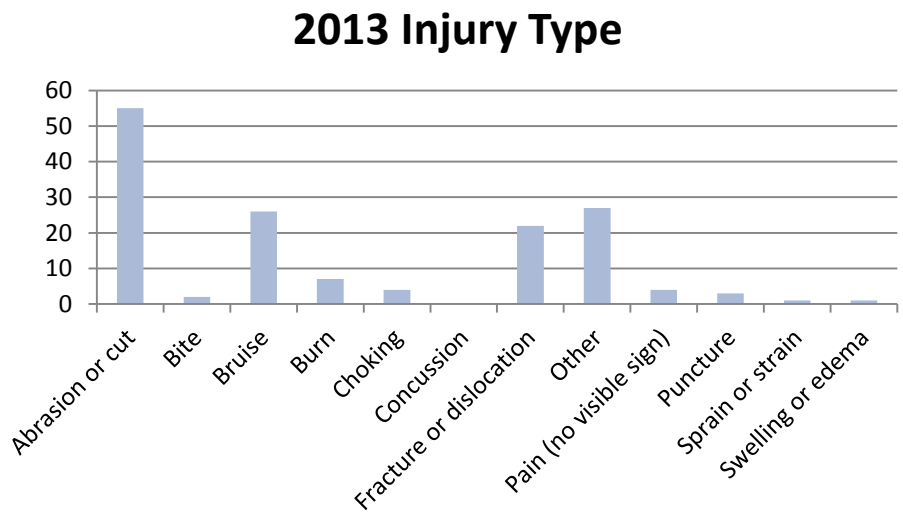
- Illegal Activity: A total of 1,008 incidents have been submitted since 2008. A significant decrease in reporting of illegal activity occurred in 2010, which corresponds directly to the change in reporting guidelines that required law enforcement involvement for the incident to warrant a CIR. In 2009 there were 348 reports of illegal activity, in 2010 there were 45 incidents, in 2011 there were 75 incidents, in 2012 there were 78 reports and in 2013 there were 64 reports. The DDD requires that any illegal activity that involves a participant in which there is law enforcement involvement, including, but not limited to, arrests, incarceration, criminal court appearances/changes, and illegal drug use be reported as a CIR.
- Unplanned Medical: Any unplanned hospitalization that results from a life threatening illness or injury is reportable to the DDD. A total of 1,144 incidents have been reported since 2008, and like several other categories a decrease in

reporting occurred in 2010. This is due to the change in guidelines that requires a hospitalization to be life-threatening in nature to justify a CIR. In 2009 there were 281 reports submitted, 142 reports in 2010, 137 reports in 2011, 118 reported in 2012 and in 2013 there were 148 reports of Unplanned Medical.

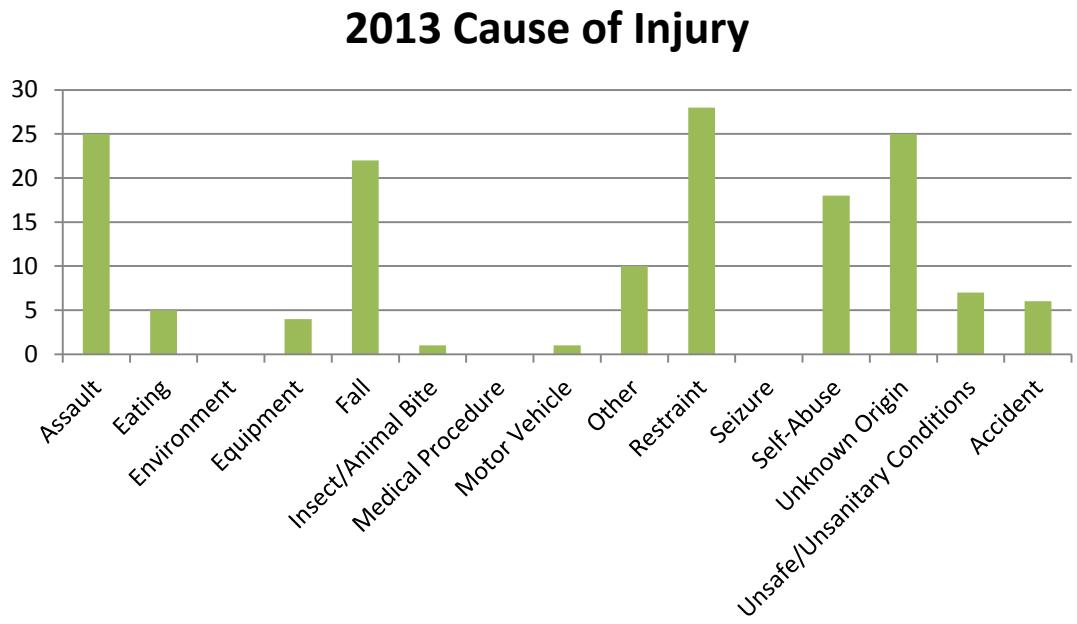
- Injury: A total of 1,024 injury reports have been submitted since 2008. In 2011, reports of injuries increased by nineteen incidents from 2010. In 2012, reporting of injuries decreased by 40 incidents, totaling 118 reports and in 2013 reports again increased by 34 incidents. Injuries reportable to the DDD include those that are classified as "severe" which means that medical attention beyond first aid was required to treat the injury, or if the cause of injury was unknown.
- Highly Restrictive Measures: Reporting of highly restrictive measures has shown an increase since 2008, with the largest variation in reporting occurring between 2010 and 2011, with an increase of 46 incidents. This increase may be attributed in part to three providers showing an increase of ten or more incidents in 2011. Highly Restrictive Measures utilized that are not part of an approved plan are reported to the DDD. This includes restrictive measures that are not implemented as written and approved by the providers Human Rights Committee. Several providers have implemented policies that prohibit any type of highly restrictive measure to be written into plans, which results in these providers reporting any restrictive procedure utilized to ensure health and safety of all participants and community members. A total of 1,228 reports have been submitted since 2008.
- Alleged Perpetrator of Altercation: Since 2008, 597 incidents have been submitted within this category. Reporting has decreased each year since 2008 with the exception of 2011. In 2010, 61 incidents were reported, a decrease of 59 incidents from the previous year; however reporting increased by 45 incidents in 2011. In 2012, the number of reports again decreased by 20, with total reporting of 86 incidents. The reports again decreased in 2013 with a total of 35 incidents. These decreases may be due to CIR training provided annually in December. The DDD requires reporting of altercations that result in severe injury to the victim, which is defined in the CIR Guidelines. Altercations may also be reported if the incident coincides with a participant's increase in behavioral issues or with services being in jeopardy.
- Suicide Attempt: From 2008 through 2013, 510 incidents have been submitted within the suicide category. Annual reporting of suicide threats/attempts decreased dramatically in 2010, when CIR guidelines were revised to eliminate the reporting of threats made without a plan or means to follow through. Thirty-one incidents were reported in both 2010 and 2011. In 2012, 50 incidents were reported for 32 participants. In 2013, there was an increase of four reports from 2012, CSPs reported 54 incidents.
- Victim of Altercation: In the past six years, 471 incidents have been submitted regarding victims of altercation. In 2008, the incident count was 113, with the next highest year of reporting being 2010 with 96 incidents. Since 2008, reporting in this category has generally tapered, with the exception of 2013 which 56 incidents reported, this was an increase of two from 2012. Victim of Altercation reports are submitted when a participant requires medical attention as a result of an altercation.

- Unplanned Psychiatric: The DDD requires any unplanned inpatient psychiatric hospitalizations be reported per CIR Guidelines. In 2013, providers reported 112 incidents of unplanned psychiatric hospitalization. This is a decrease of five incidents since 2012. Over the past six years, a total of 601 incidents have been submitted.
- Missing Person: Reported incidents of missing persons have remained relatively stable over the past six years, with the greatest variation being an increase of 19 reports between 2011 and 2012. All other years within this timeframe reflect a difference of 16 or less incidents, with the total number of reports since 2008 being 449. Missing person reports are submitted to DDD when a participant is on an unauthorized absence and at risk of harm to self or others. If the person has a protocol or a plan that addresses unauthorized absences, a report is not necessary unless the plan is not implemented as written.

INJURY:

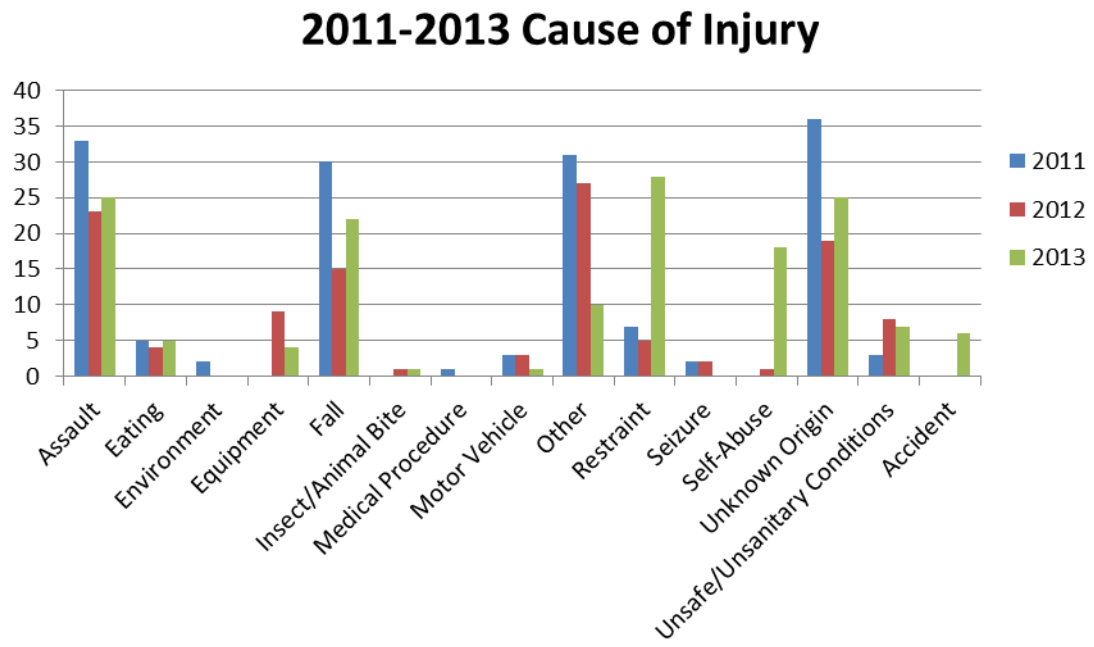


In 2013 there were 152 injuries reported to DDD. The most frequently reported injuries are Abrasion or cut (55), Other (27), Bruises (26) and Fracture or dislocation (22). There were 27 "Other" types of injuries reported to the DDD, these types of injuries include but are not limited to: choking, concussion, bites, and burns. Two of the 152 reports were incorrectly categorized as Injury, and 12 of Other types of injuries were incorrectly categorized. Each of the reports should have been categorized under other applicable categories: Abrasion/cut, Bruise, Fracture/dislocation and Pain (no visible sign).



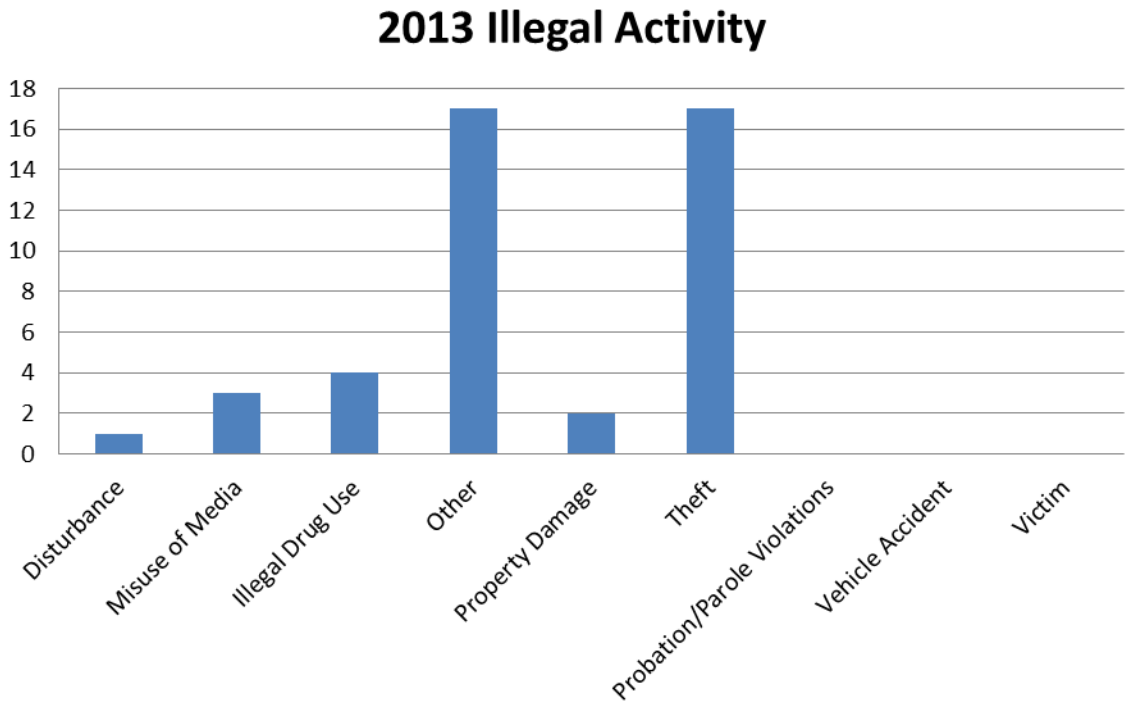
Cause of Injury data reflects injuries of Restraint as the most frequently reported Cause of Injury reported to the DDD, with 28 reports in 2013. Other top Causes of Injury are Assault and Unknown Origin (25), Fall (22) and Self-Abuse (18). This information seems to correlate with the leading types of injuries which are Bruises, Abrasion/cut, and Fracture/dislocation. Ten incidents captured as Other within Cause of Injury were reviewed by the DDD. Through this review, it was determined that eight of these were incorrectly categorized and would of better fit under the categories of restraint, fall and self-abuse.

Further analysis of the Cause of Injury in Restraints showed there were 19 reports for one agency, for which further follow up will occur.

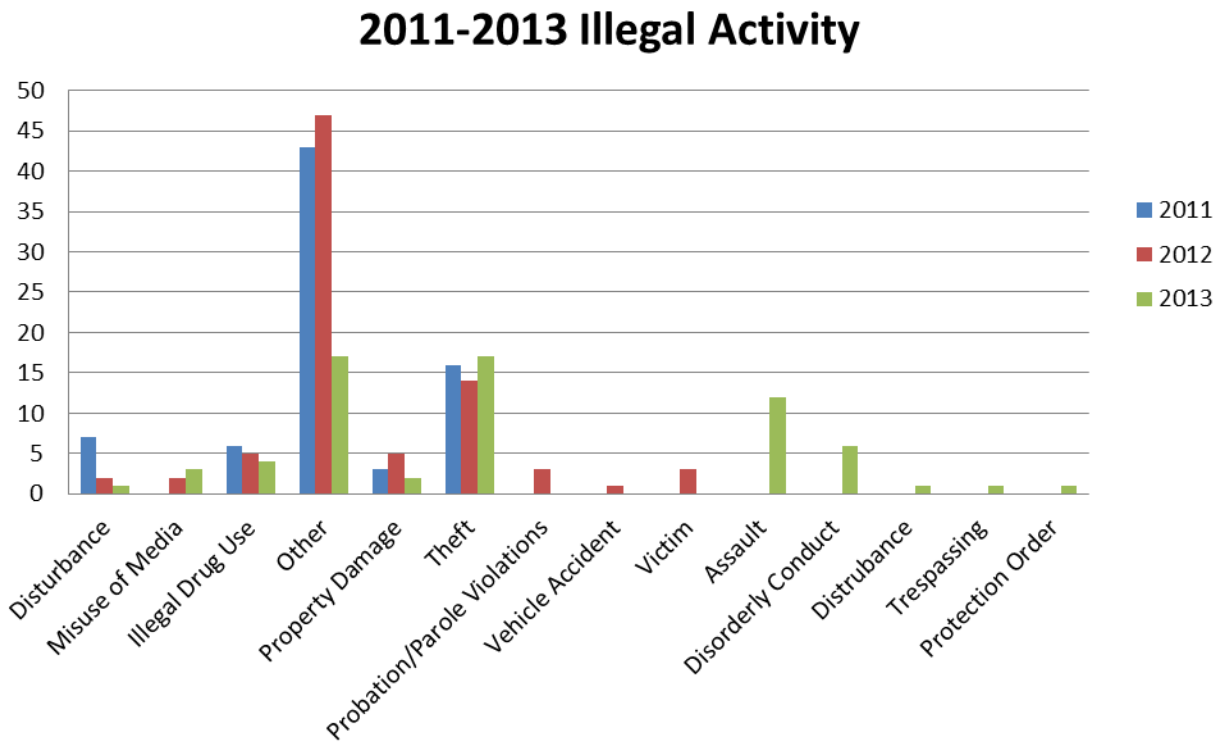


In 2013 there was an increase of 35 incidents relating to Injury reports from 2012. The leading causes and types of injuries have remained consistent. Within the injury type an increase was noted in the following: Abrasion/Cut, Fracture/Dislocation, Burn, Pain (No Visible Sign), Puncture and Other. An overall increase of 35 incidents reported within the Injury category resulted in an increase in Restraints, Falls and Self-Abuse which are the most frequently reported Causes of Injuries.

ILLEGAL ACTIVITY:

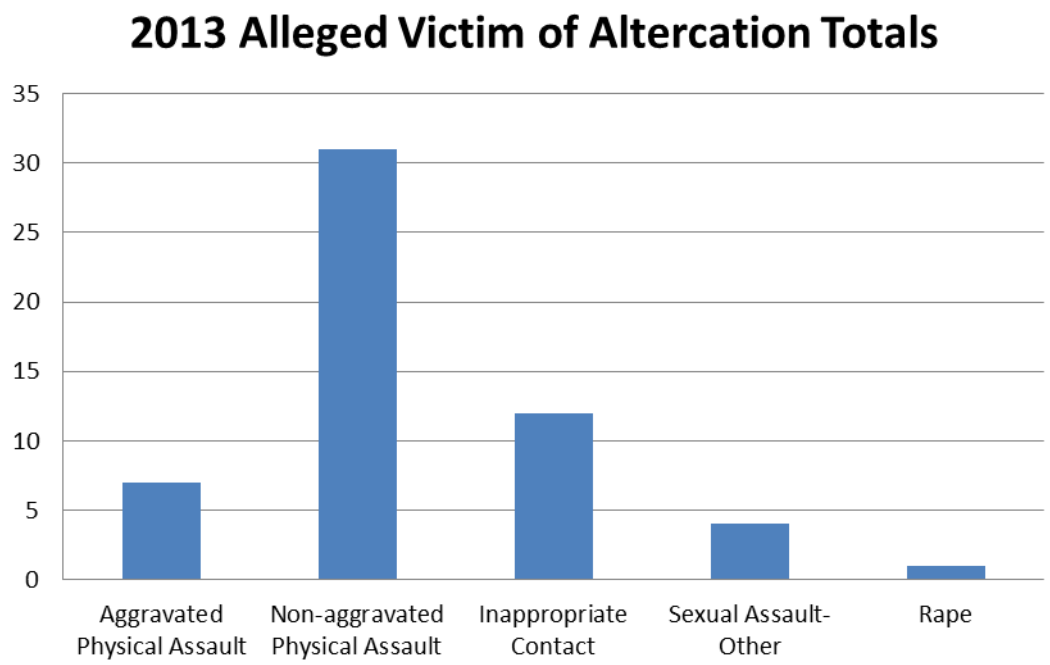


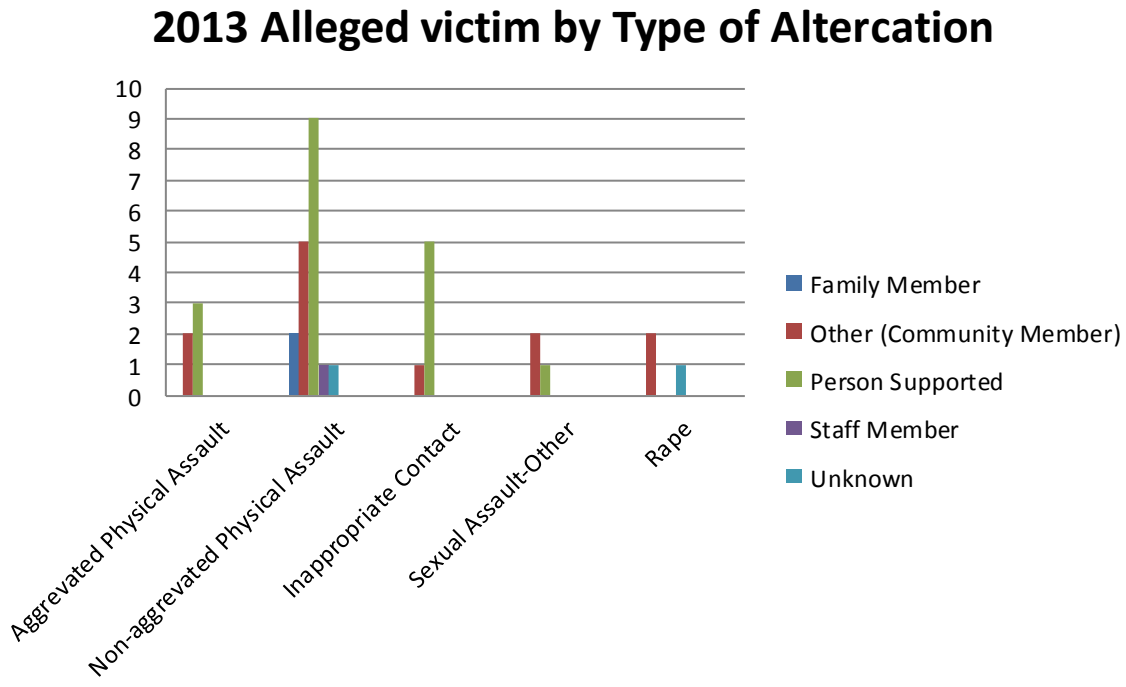
During an analysis of the 2013 data regarding incidents reported as Illegal Activity "Other" it was determined that there weren't enough similarities in reported Illegal Activity to create new categories which would indicate a need for additional drop down options within this reporting category. Some of the "Other" incidents were related to contributing to a minor, possible child abuse, housing minors, false reporting to the police and trespassing. No incidents were reported for Probation/Parole Violations, Vehicle Accident, and Victim of Fire.



Illegal Activity incidents reported in 2013 totaled 65; with 34 of these reports being identified under the category of Other (17) and Theft (17). Incidents identified as "Other" have significantly decreased from previous years. In 2012, there were 47 incidents reported under this category and decreased by 30 reports in 2013. An analysis of previous year's data indicated a need for additional reporting categories which were added in December 2013.

ALLEGED VICTIMS/PERPRETRATORS OF ALTERCATIONS:



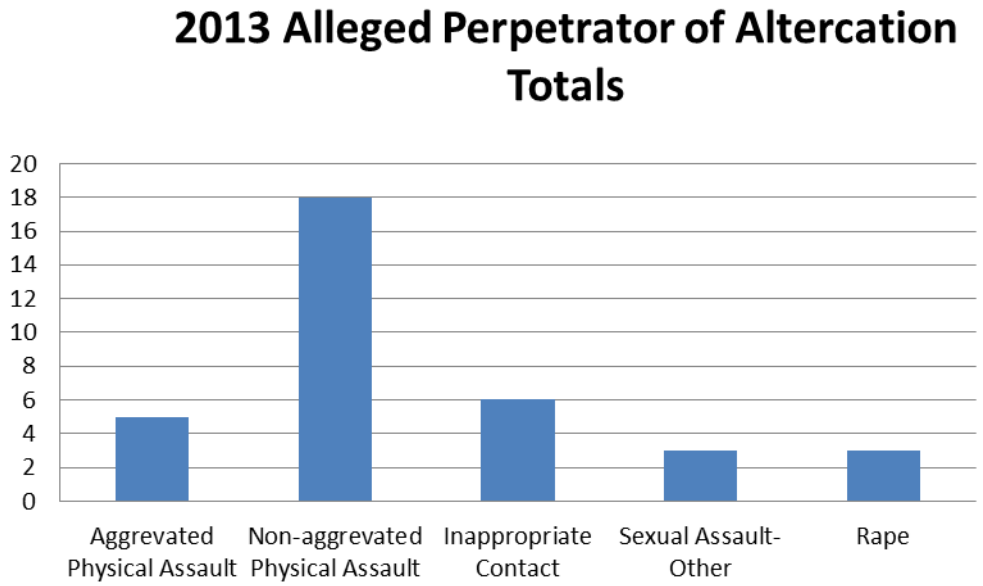


The report demonstrates who perpetrators were for each type of altercation under the Alleged Victim section of the online CIR form.

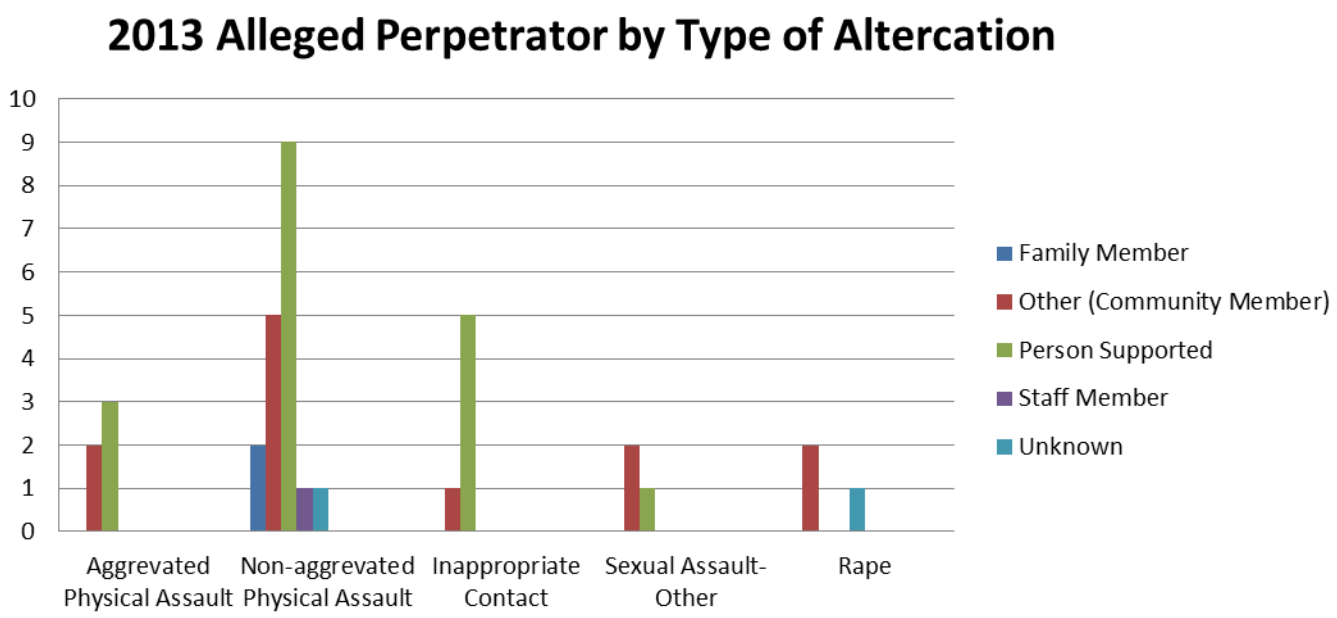
The most frequently reported types of altercations are incidents in which one participant has assaulted another participant. This relates to the data indicating that incidents happen most frequently in residential and segregated settings where participants are in close proximity to each other. Non-aggravated assault and inappropriate contact incidents were reported most frequently, with 31 reports and 12 reports, respectively. This is a decrease from previous years' data.

ALLEGED PERPRETRATOR/VICTIM OF ALTERVATION:

The information below indicates that there were 18 incidents in which a participant was the alleged perpetrator of non-aggravated physical assault, six incidents of inappropriate contact allegations, five aggravated physical assault allegations, three sexual assault-other allegations, and three incidents where participants were accused of rape.



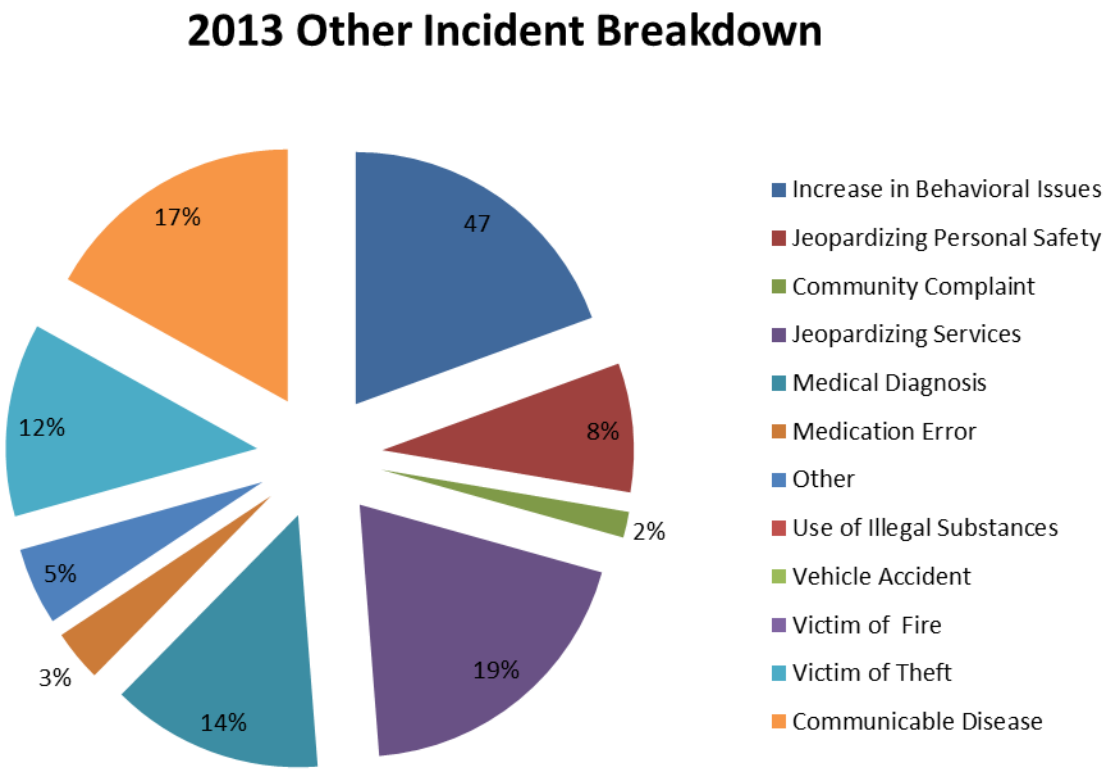
The number of altercations reported in 2013 in which a participant was the perpetrator of an altercation is reflected in the graph above. The total number of reports in this area is considerably lower than the number of reports submitted in which a participant was the victim.



The report above demonstrates who the victims were for each type of altercation under the Alleged Perpetrator section of the online CIR form. Reports for People Supported are the highest in three of the five categories. The second most frequently reported Victim group is Other or Community Member.

The two most frequently reported types of altercations are non-aggravated physical assault and inappropriate contact. Again, incidents are likely to happen where people spend most of their time and those whom they spend most time with are likely to be victims.

OTHER:



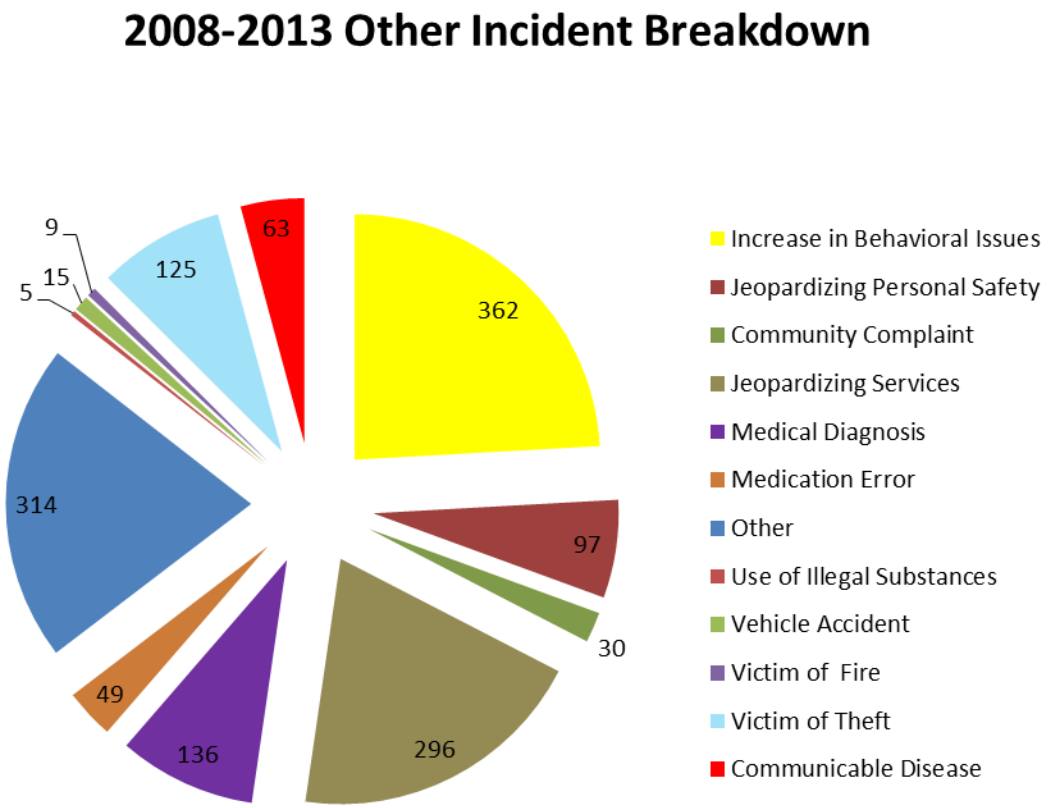
There are total of 242 CIRs that fell into the "Other" incident category during 2013. These included various reports, ranging from Communicable Disease to Victim of Theft. Of the total number, 47 incidents due to an increase in Behavioral Issues and Jeopardizing Services, 41 reports due to Communicable Disease, 33 had a Medical Diagnosis, 30 were Victim of Theft, 20 were Jeopardizing Personal Safety, and eight had a Medication Error. Twelve of these reports are unique and do not align with any single category. Some examples of these reports are:

- Change in health
- Choking incident
- Family removing ventilator
- Aspiration
- Victim of shooting
- Drug use

Upon review of the unique reports it is clear that some were categorized incorrectly. Of the 12 reports in the "Other-Other" category, four should have been categorized in another category. This is a decrease from 2012 when 21 incidents were incorrectly captured within the "Other-Other" category. The CIR/QA team has provided follow up

and technical assistance to those providers which have incorrectly categorized incidents, as well as with DDD staff to ensure consistency during peer review of incidents.

It should also be noted that Communicable Disease increased by 27 reports. This is likely due to an increase awareness of communicable diseases and reporting responsibilities in this area. Communicable Disease reported the biggest increase from 2012 to 2013. All other increases were less than six. Increase in behavioral issues and jeopardizing services both reported 47 incidents in 2013, a decrease of 21 and 38.

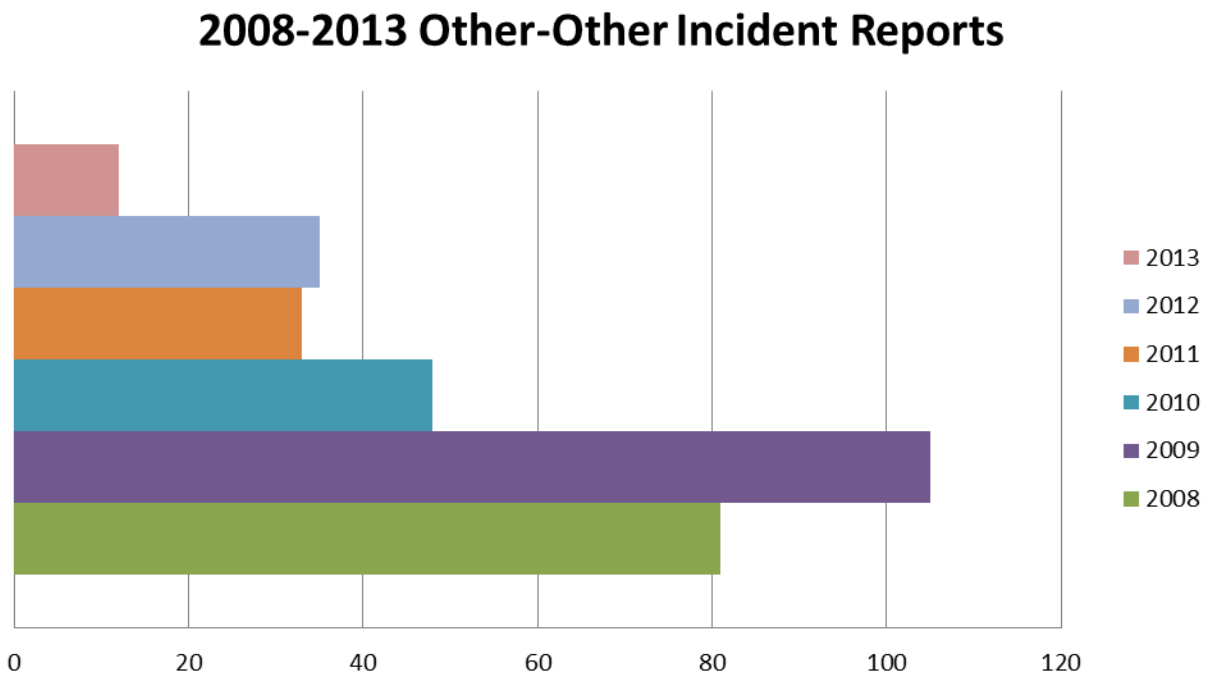


From 2008 through 2013, reports in the Other category totaled 1,501. A majority of these incidents (364) were categorized as increased in behavioral issues. The second most frequently reported category is Other-Other (314), followed by Jeopardizing Services (296). The 2013 data shows a decrease in "Other-Other" by 23 reports which indicates that Program Specialists are continuing to have increased scrutiny of incident categorization.

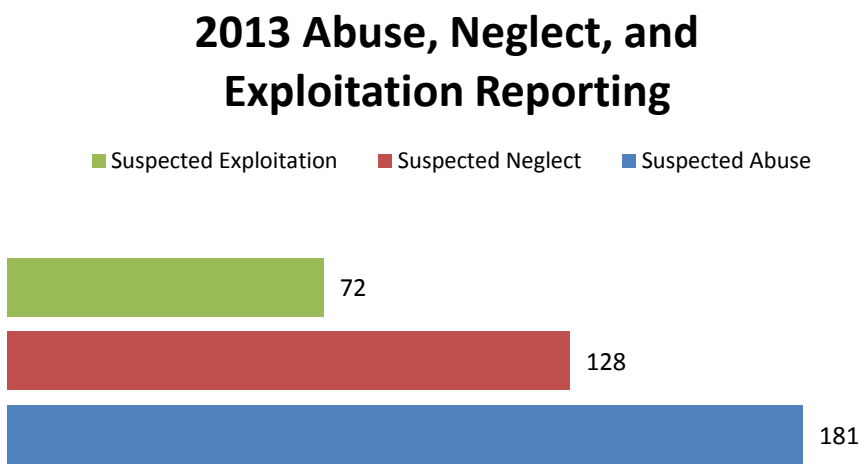
It is evident that when the Critical Incident Reporting Guidelines and online reporting form were developed, most incidents were being reported as Other-Other. As DDD and

CSP staff become better informed and other options have been added within the online reporting form, incidents are categorized more accurately.

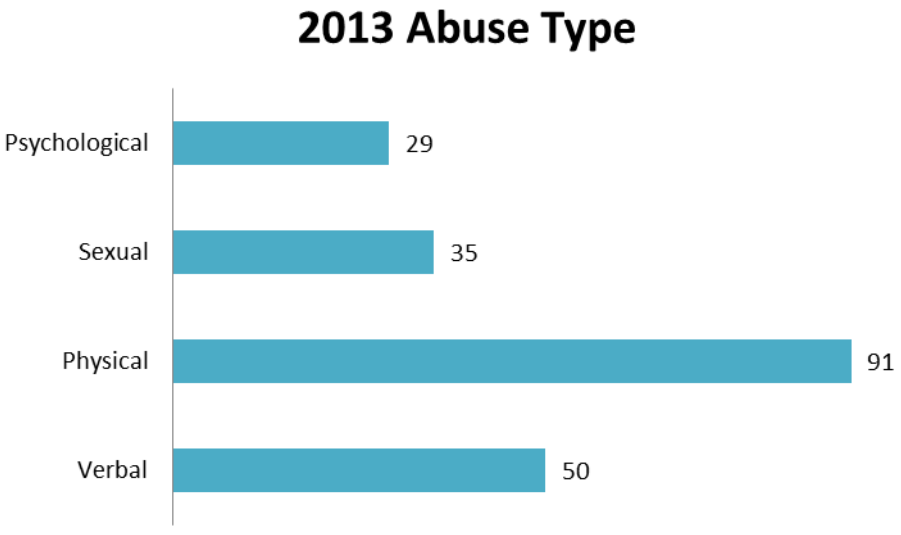
The graph below reflects the fluctuations in reporting under the Other-Other category. Between 2008 and 2013, the number of Other-Other incidents decreased, with the exception of 2009 and a slight increase in 2012. DDD continues to monitor and provide training to CSPs regarding categorization of incidents.



ABUSE, NEGLECT AND EXPLOITATION:

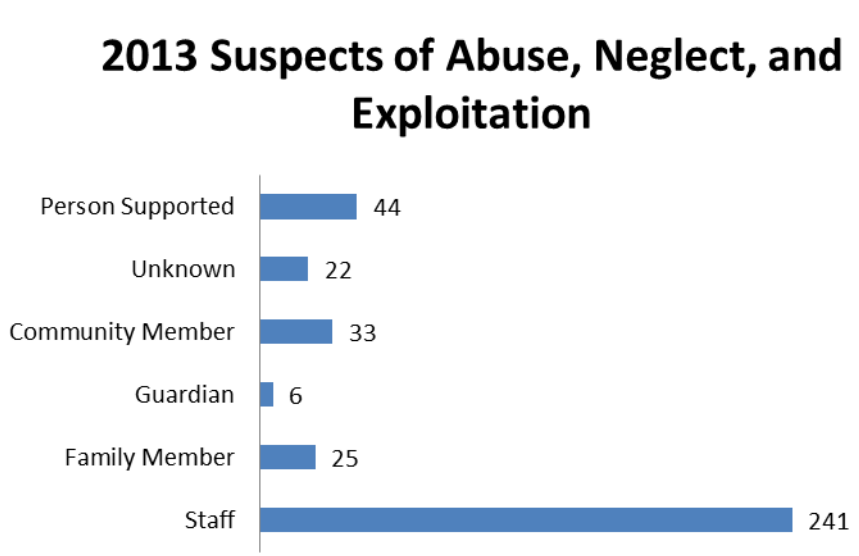


Incident reporting in the ANE category for 2013 was as follows: 181 Abuse allegations, 128 Neglect allegations, and 72 Exploitation allegations. Suspected Abuse has historically been more frequently reported than neglect and exploitation. Within the CIR form, reporters are required to specify whether the Abuse was Verbal, Physical, Psychological, or Sexual, which is reflected in the graph below. It is noted that the total number of Verbal, Physical, Sexual and Psychological allegations equal 205, whereas 181 allegations of Abuse incidents were submitted. This is due to providers having the option to choose more than one type of alleged Abuse within a single incident form.

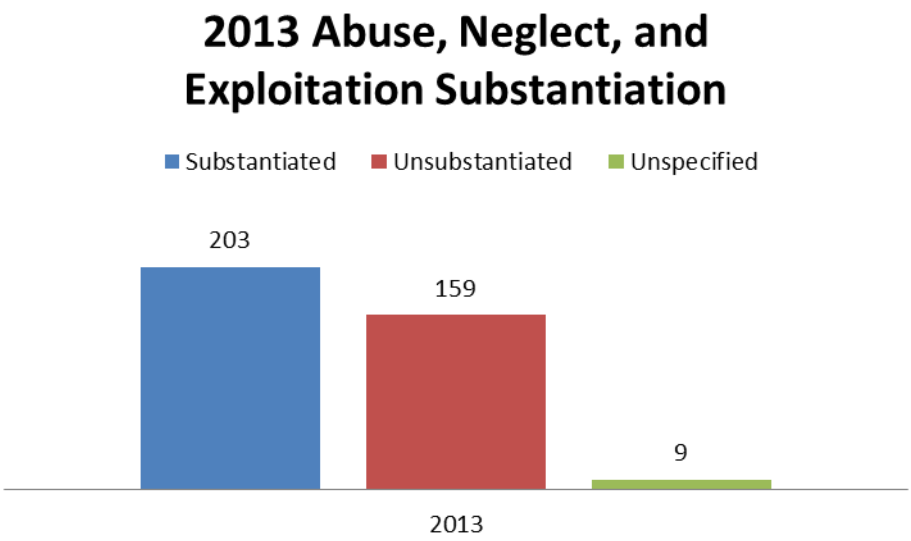


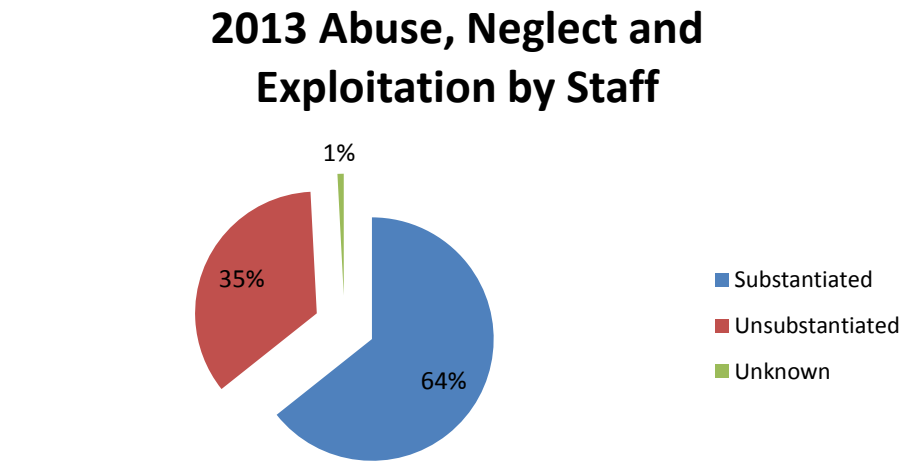
As the graph above indicates, the number of allegations of Physical Abuse is substantially higher than other types of Abuse at 91 allegations, followed by allegations of Verbal Abuse at 50 reports. Sexual and Psychological allegations are the lowest at 35 and 29 reports, respectively.

In the graph below a total of 371 ANE allegations were made in 2013. Of those, 241 were against staff members; 44 were against other participants using supports; 33 were against Community Members; 25 allegations were against Family Members; 22 were Unknown; and 6 allegations were made against Guardians.

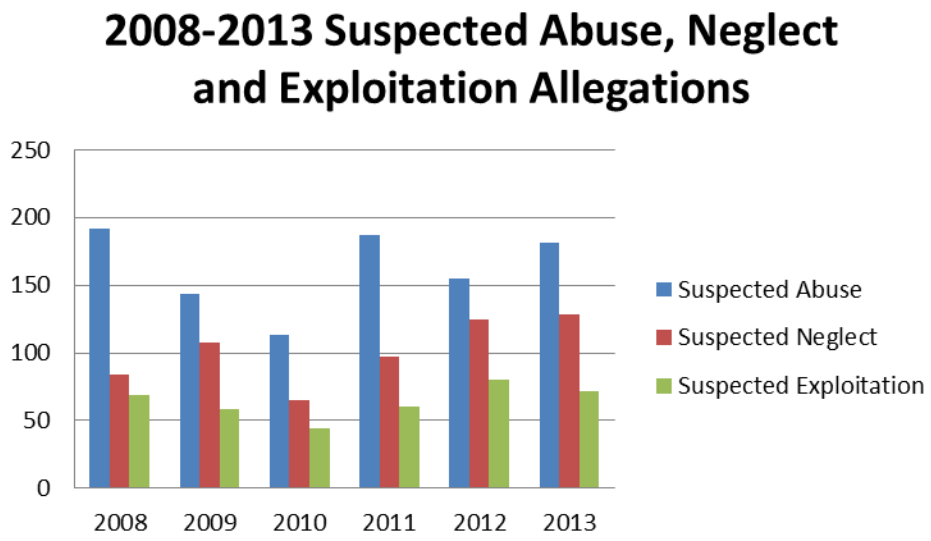


In 2013, 203 allegations were Substantiated, 159 were Unsubstantiated and 9 were Unspecified. Unspecified is an indication that the Program Specialist marked neither the Substantiated nor the Unsubstantiated section while reviewing the CIR online report. Follow up will occur with Program Specialists to ensure incidents are accurately categorized. The data shows a 55% Substantiation rate among all reported allegations of ANE.

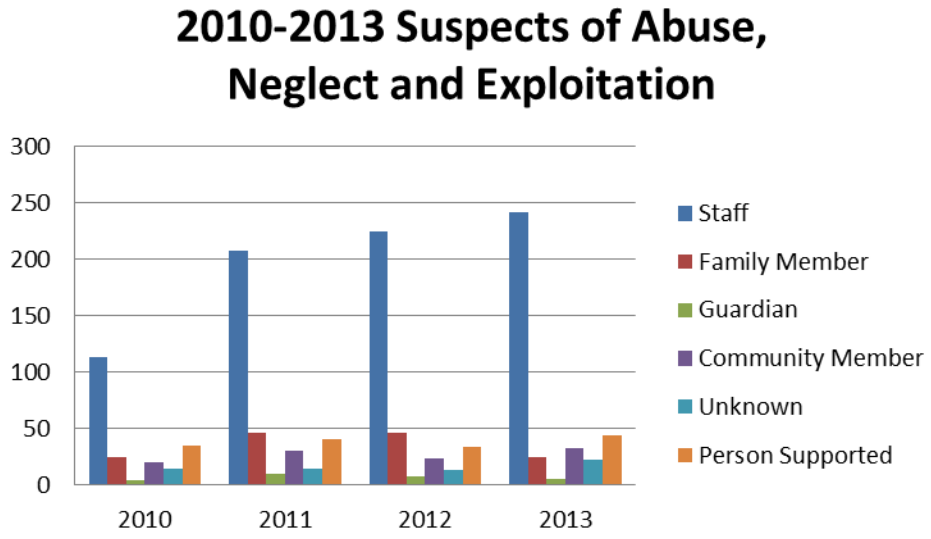




A total of 241 total incidents were reported for ANE against staff providing services and supports in provider agencies. Of the 241 reported incidents 155 were Substantiated, 84 were Unsubstantiated and two were Unknown. After further analysis the two incidents that are categorized as neither Substantiated nor Unsubstantiated, investigations conducted by the provider were inconclusive.



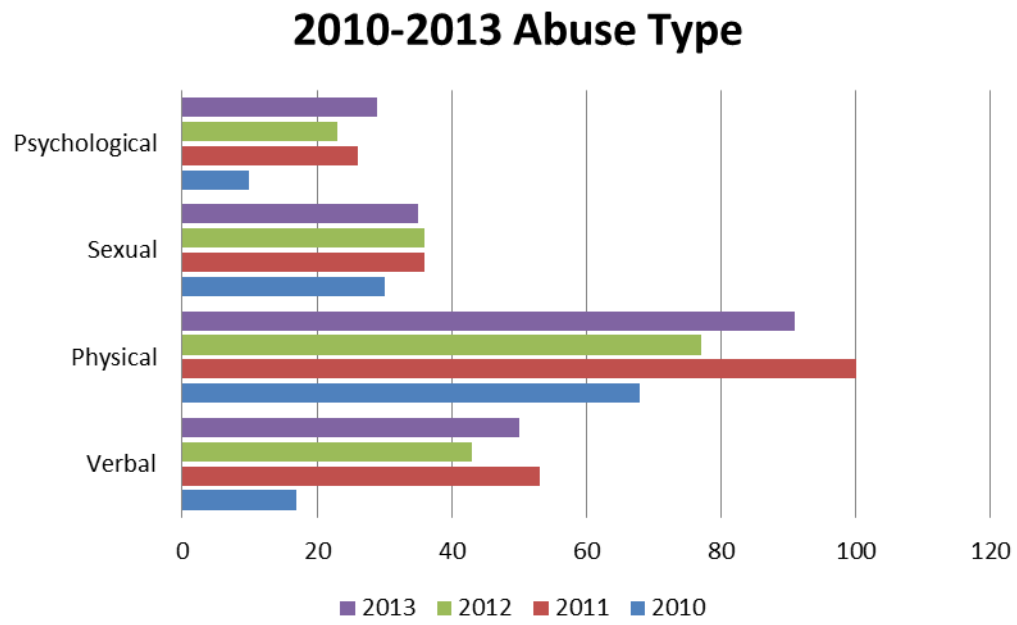
It should be noted that the total highest reporting for all three categories was in 2008 and gradually decreased until 2011, when a slight increase occurred. In 2013, suspected Abuse allegations, again, increased by 26 reports from 2012.



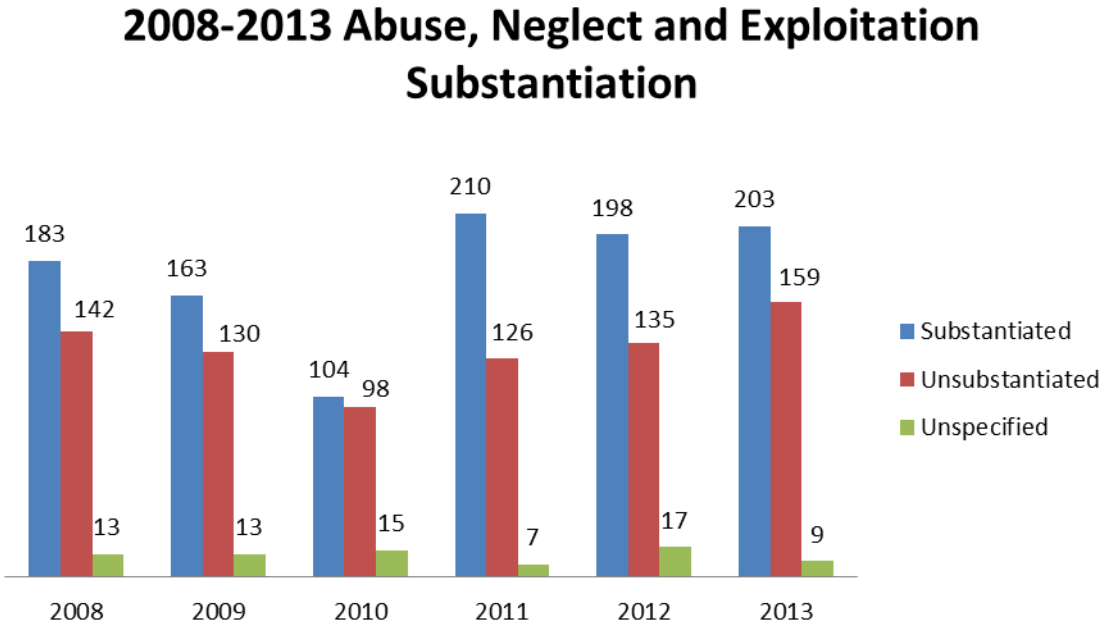
In 2013, incidents of ANE increased by 21 incidents from 2012. Allegations against Guardian and Community Member decreased. All other "Suspected by" categories increased. Incidents in which staff was accused of ANE totaled 241, an increase of 16 incidents from 2012.

From 2010-2013 the number of reported incidents increased in all but two categories, Family Member and Guardian allegations decreased from previous years. The reason for this could be attributed to training that has assisted providers in the reporting

requirements of ANE. Also, this particular category is reviewed during monthly individual file review.



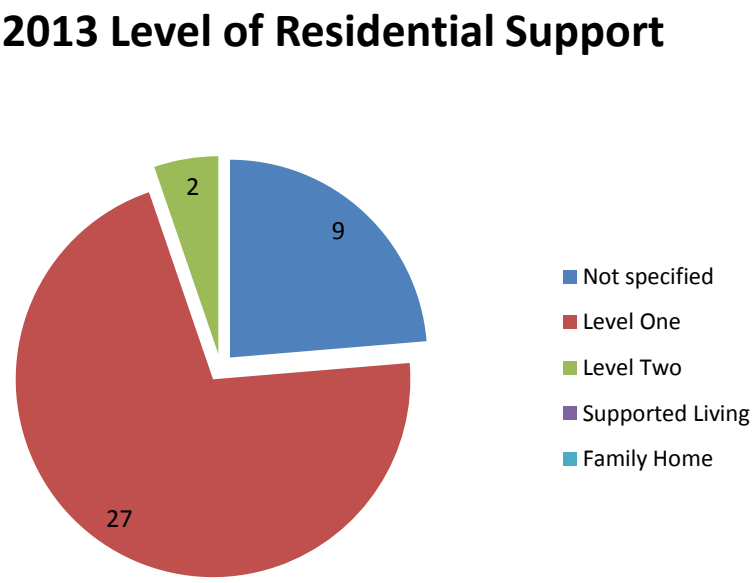
Increased reporting occurred in most categories of Abuse in 2013, with the exception of Sexual Abuse which decreased by one. In 2013, allegations of Physical Abuse increased by 14 incidents, allegations of Verbal Abuse increased by seven incidents, and Psychological Abuse increased by six incidents.



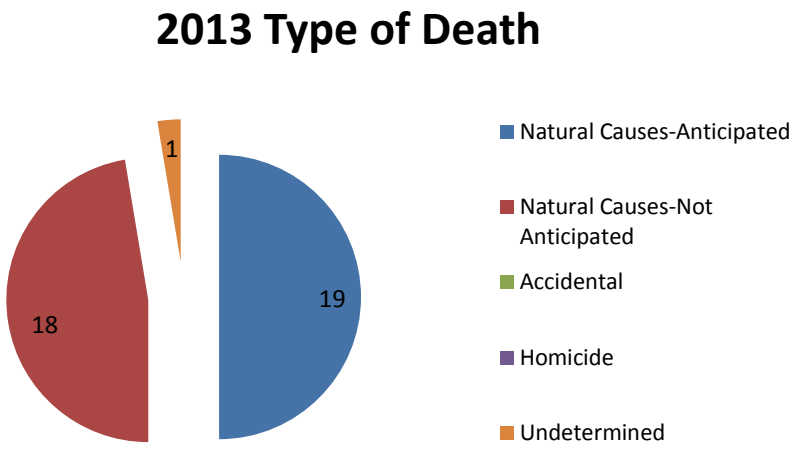
Since 2008, the trend of substantiation of ANE allegations has remained relatively consistent, with the lowest substantiation rate of 47% in 2010 and the highest substantiation rate of 61% in 2011. 2008 and 2009 substantiation rates were 54% and 53%, respectively. The DDD will continue to monitor these trends and provide technical assistance regarding investigations to providers as necessary.

MORTALITY ANAYLSIS:

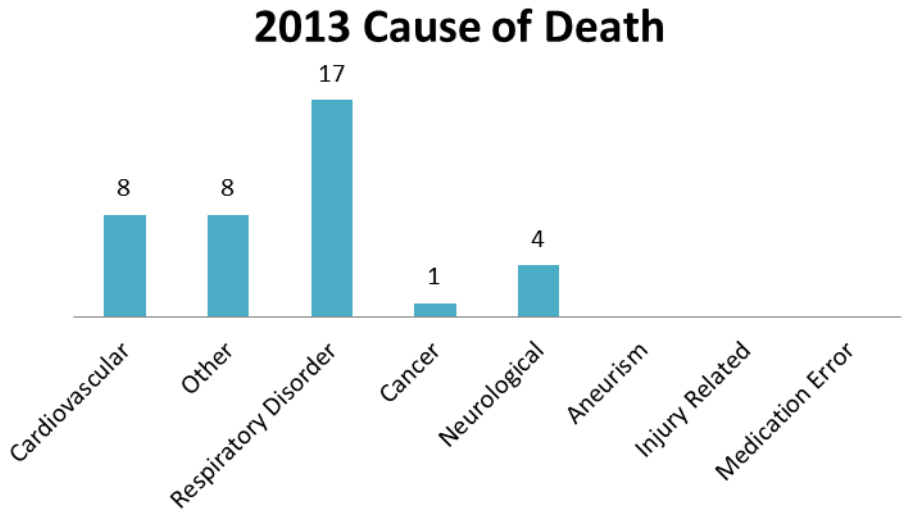
By definition, state developmental disability systems support people from an early age until the end of life. Supporting individuals through the end stages of their life is a critical function that CSPs provide to participants. In South Dakota, the relatively low number of deaths each year makes it difficult to detect annual trends. The DDD reviews all deaths and may conduct investigations of any deaths that are accidental, unexplained, or occur amidst allegations of abuse or neglect.



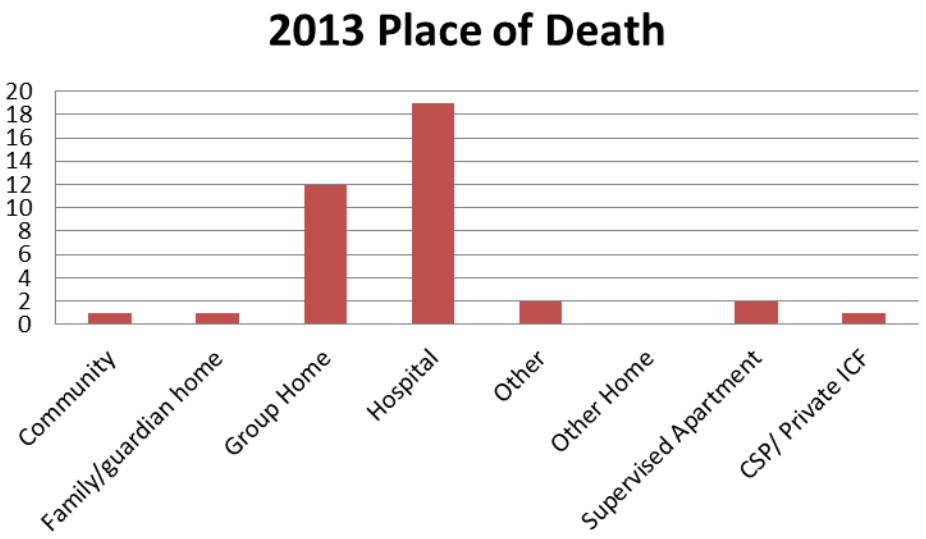
In 2013, there were 38 deaths reports submitted by CSPs. Of these, 27 participants were receiving residential supports in a Group Home (Level One) setting and two in a Supervised Apartment (Level Two). Instances in which the level of supervision is "Not Specified," indicates that the participant did not receive residential supports from the CSP but received at least one other waiver service. There are no reported deaths that occurred in the Family Home or Supported Living.



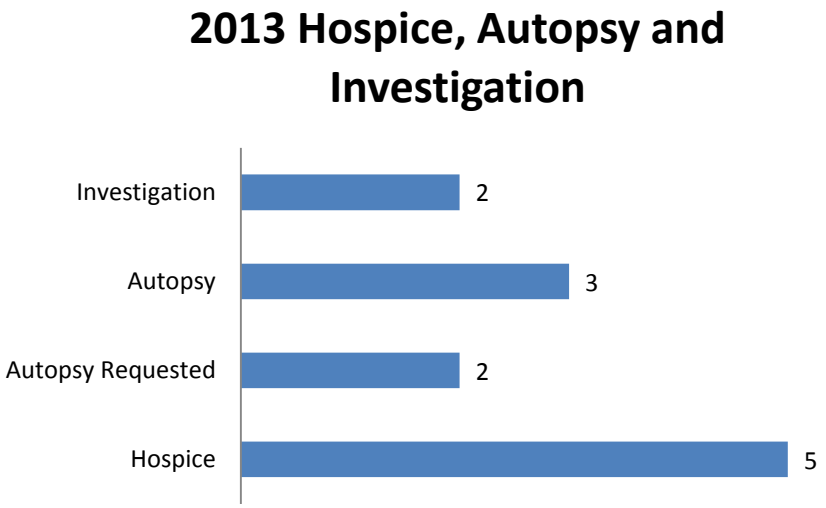
As seen in the graph above, 19 deaths in 2013 were due to Natural Causes-Anticipated and 18 Natural Causes-Not Anticipated, and one Undetermined death. The single Undetermined death was categorized as such due to an inconclusive autopsy report. There were no Homicides, Accidental deaths or Suicides reported in 2013.



The leading causes of death in 2013 were Respiratory (17), followed by Cardiovascular (8) and Other (8). Other category indicates that the cause of death did not fall into an available option within cause of death. There were no deaths resulting from Aneurism, Injuries, or Medication Errors.

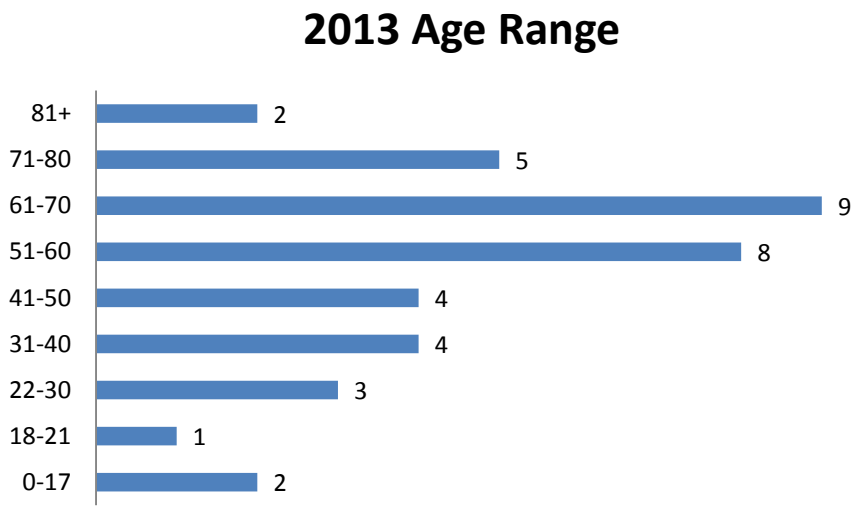


As the graph above demonstrates, 12 of the 38 incidents of death occurred at a Group Home, while 19 occurred at the Hospital, two occurred in Other and Supervised Apartment locations, and the remainder occurred either in the community, other home, or provider day program. Of the two deaths that were reported in an "Other" location, one occurred in a relative's home and the other incident should have been categorized as group home. Further analysis was completed for Place of Death in correlation to Anticipated and Not Anticipated, the results showed that there were nine deaths that occurred in the Hospital that were Anticipated and 10 occurred in the Hospital that were Not Anticipated.

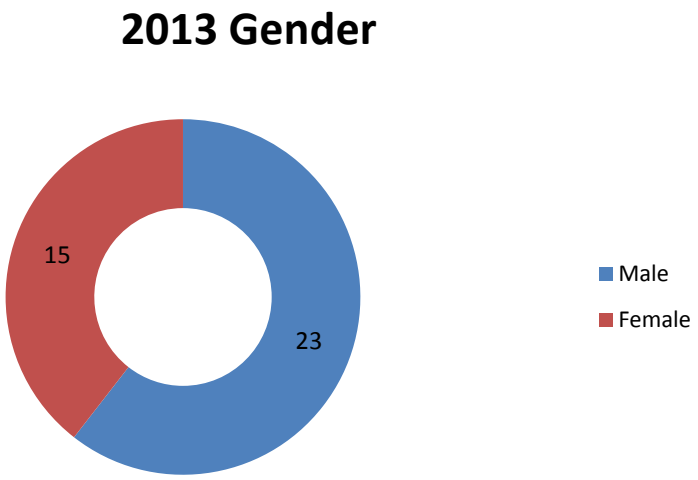


Of the 38 deaths that occurred in 2013, 19 of these were anticipated and hospice care was provided for five of the people. With the CIRs that reported an investigation took place, one was categorized as Natural Causes- Not Anticipated, suffering from a brain stem

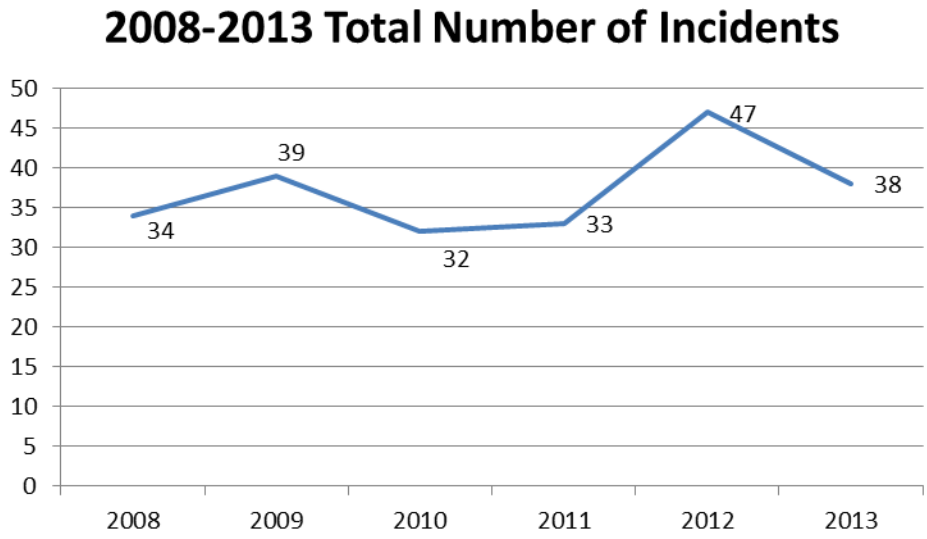
bleed. The other was Undetermined which after investigation should have been categorized as Natural Causes- Not Anticipated, suffering from blocked artery. The investigations that this graph is referring to are the internal investigations conducted by the CSP.



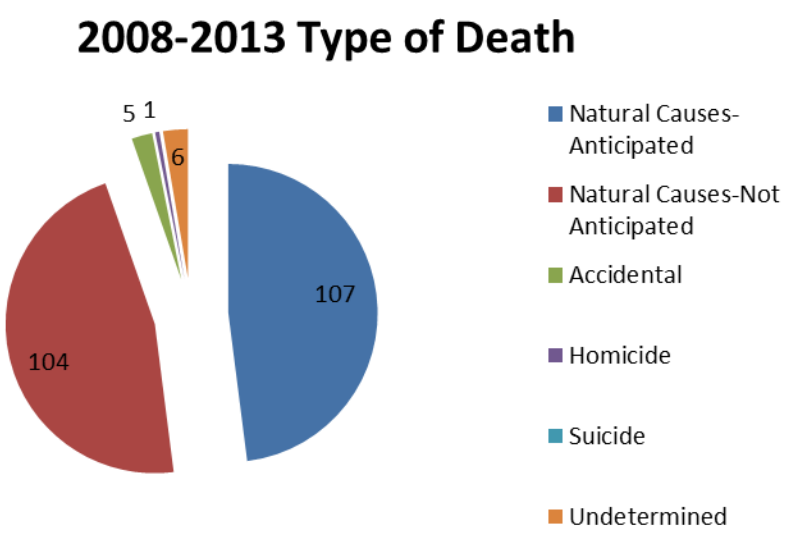
The graph above reflects the number of deaths in each age category. Nine participants in the 61-70 year old age range died in 2013, eight in 51-60, five 71-80 and four in each of the age categories of 41-50 and 31-40. Three deaths occurred in the 22-30 age range category and two participants in the age categories of 0-17 and over 81 were supported until the end of life. One participant in the 18-21 age range was supported until the end of life.



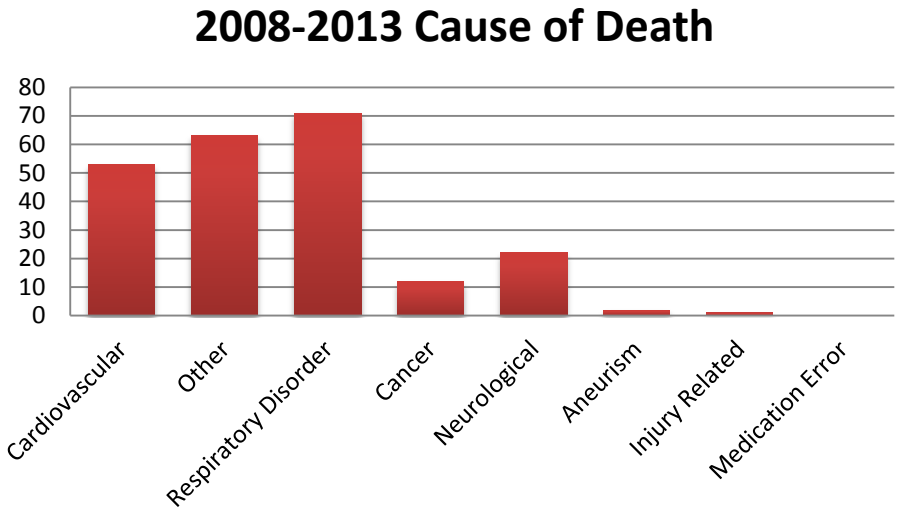
In 2013, 23 males and 15 females passed away. The percentage of males deceased in 2013 and accounts for 61% of deaths; whereas the percentage of females accounts for 39% of deaths.



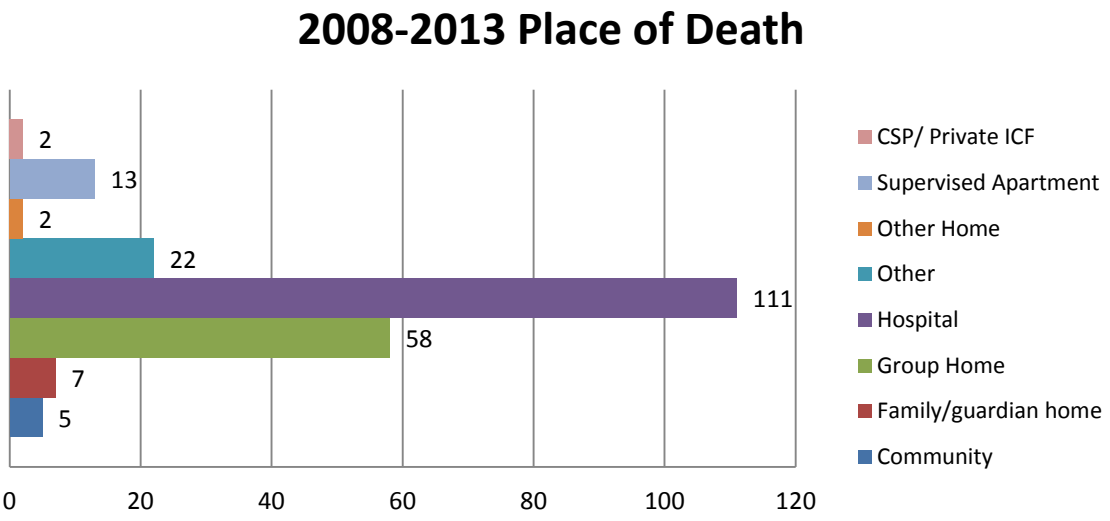
Over the course of the past six years, mortality rates have remained fairly stable. In 2010, the number of deaths decreased from the previous year, and has continued to increase since then until 2013 when this decreased by nine.



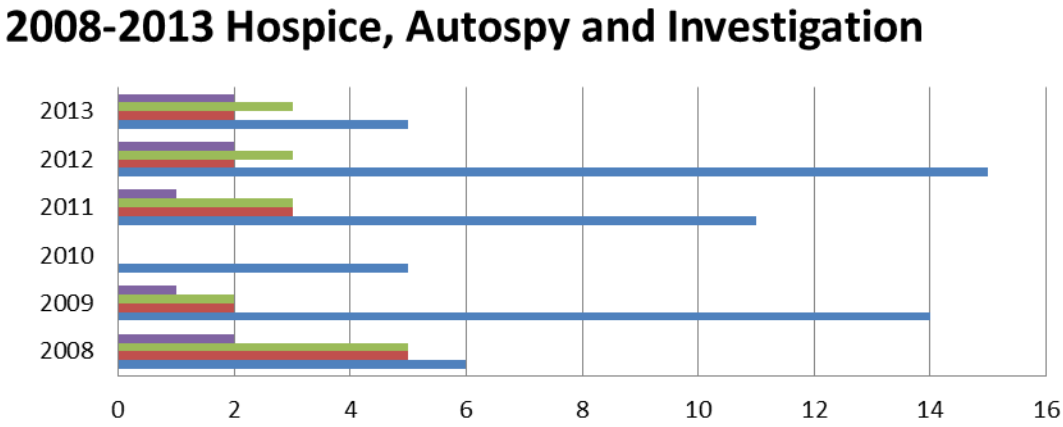
From 2008 through 2013, the leading type of death was Natural Causes-Anticipated at 107, followed by Natural Causes-Not Anticipated at 104 deaths. Six deaths were Undetermined, five were Accidental, and one was a Homicide. The Homicide occurred in 2008 when a participant and two community members were shot in a common area of their apartment building.



The leading cause of death from 2008-2013 is Respiratory Disorder, followed by Other and Cardiovascular.



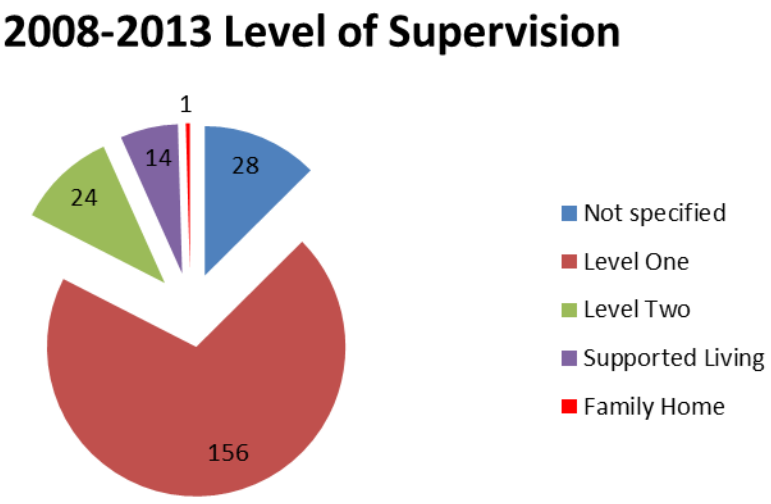
As the graph above demonstrates, 111 participants have passed away in Hospitals, which is just over half of the total deaths reported. Fifty-eight deaths occurred in Group Homes, and 22 occurred in "Other" locations. This information is also consistent with the 2013 data.



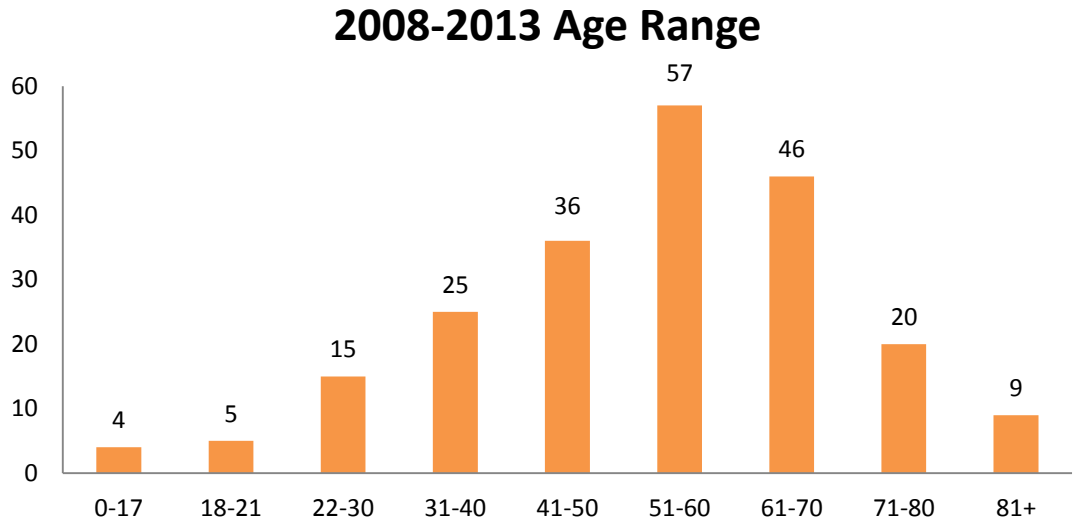
	2008	2009	2010	2011	2012	2013
Investigation	2	1	0	1	2	2
Autopsy	5	2	0	3	3	3
Autopsy Requested	5	2	0	3	2	2
Hospice	6	14	5	11	15	5

The graph above reflects actions taken prior to (hospice services) and after (autopsy and investigation) the death of a participant occurs. In 2009 there was a significant increase in the use of hospice, whereas the number of autopsies requested and performed remained relatively low. Providers should be commended for assisting participants in accessing hospice services which allow them to remain in their own home.

The rate of death investigations has remained relatively steady, ranging between zero to two investigations per year. Investigations may be initiated and completed by a number of agencies including the provider, law enforcement, Medicaid Fraud Control Unit, Division of Developmental Disabilities, and/or the Department of Social Services. Two investigations in 2013 were conducted by the provider.



The graph and table above indicate that from 2008-2013, 156 of those who passed away were receiving Group Home (Level One) residential supports at the time of their death, followed by Supervised Apartment (Level Two) supports, Not Specified and Supported Living. Again, if the level of supervision is "Not Specified," this is an indication that the participant did not receive residential supports from the provider.



Of the 185 deaths that occurred from 2008 through 2013, 57 of those participants were in the 51-60 age range, followed by 46 deaths in the 61-70 age range, then 36 deaths in the 41-50 age range. This may be due to the increase in aging population in community-based services. The age ranges with the lowest number of mortalities are 0-17, 18-21 and over 81, likely due to the participant population being low system-wide in those age ranges. In 2013, the age range with the highest number of mortalities was 51-60, which is consistent with the overall data gathered from 2008-2013.

SYSTEMS IMPROVEMENTS IN 2014

The CIR process is an important and continuous aspect of DDDs' quality management system. Thorough review of the data and substantive dialogue with a variety of stakeholders resulted in a number of planned systems improvements. One of the primary functions of this annual report is to provide interested parties with a summary of planned systems improvements. They are as follows:

1. CIR/QA team will provide training and information to the Core Stakeholders group regarding current incident review practices and findings of the 2013 CIR Report. Input will be sought from the group regarding any recommendations for incident system improvement.
2. The DDD CHOICES waiver manager will share CIR data on a quarterly basis with the Internal Waiver Review Committee (IWRC), who will review and provide recommendations to the CIR/QA team and DDD Director;
3. CIR/QA team will survey providers, core stakeholders and DDD staff to determine how people are utilizing the CIR annual report information and which information would be most beneficial;
4. CIR/QA team will be conducting two different CIR trainings to provide better education to veteran and new provider staff;
5. Program Specialists will conduct technical assistance with providers as needed or requested regarding clarification for CIR Guidelines and reporting expectations;
6. DDD will provide further clarification regarding highly restrictive procedures (chemical, mechanical, and physical) definitions and specific reporting criteria;
7. DDD will provide all CSPs with an Abuse, Neglect, Exploitation informational poster to be disseminated to the people they support and employees;
8. CIR/QA team will be assisting to revise the chemical intervention definition, process and reporting criteria to better protect the rights of individuals who receive psychotropic medications regardless of diagnosis; and
9. Training will occur on an ongoing basis for Program Specialists and provider staff to ensure reporting accuracy.

The goal of these system improvements is to increase the overall quality of services and supports for people with disabilities in South Dakota.

Please direct any comments and questions about this report to Kelli Anderson, Program Specialist, at Kellij.Anderson@state.sd.us or Julie Hand, Program Specialist, at Julie.Hand@state.sd.us . Phone contact can be made with either Kelli or Julie at 605-773-3438.